

IS SOCIALIZED MEDICINE REALLY THE BEST ANSWER FOR RESOLVING AMERICA'S HEALTH CARE CRISIS?

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Access to quality health care in the United States is one of the most pressing concerns facing American constituents today.¹ In one of Monmouth University Polling Institute's most recent surveys from August of 2019, "the top issue on Iowa Democrats' minds when choosing a presidential nominee continues to be health care (55%)."² This is not surprising given that worrying about access to health care in the United States is an extremely well-founded concern based on the statistical data gathered by some of the major leaders in the health care industry.³ According to the National Center for Health Statistics, roughly 30.4 million people in the United States did not have health insurance in 2018.⁴ Although this number is not "significantly different" from the percentage of the United States' population who were uninsured in 2017, there are roughly "18.2 million fewer" Americans with health insurance than there were in 2010.⁵

Setting these disturbing figures aside, concerns regarding health care in the United States are also felt by Americans who are fortunate enough to have health insurance and access to at least some health care treatment. According to a study published by The Commonwealth Fund evaluating the health care systems of eleven countries, "[t]he United States ranks last in health care system performance" which includes last place rankings in the sub-categories of access to health

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¹ Kate Rooney, *Health Care Topped the Economy as the Biggest Issue for Voters Now, Here's Why*, CNBC (last updated Nov. 7, 2018, 10:33 AM), <https://www.cnbc.com/2018/11/07/healthcare-topped-the-economy-as-the-biggest-issue-for-voters-now-heres-why.html> ("An exit poll by NBC found that health care was the biggest issue for voters for the first time in a decade.").

² MONMOUTH UNIV. POLLING INST., IOWA: BIDEN HOLDS LEAD, WARREN ON THE CHASE 3 (2019).

³ Robin A. Cohen et al., *Health Insurance Coverage: Early Release of Estimates from the National Health Interview Survey, 2018*, NAT'L CTR. FOR HEALTH STAT., May 2019, at 1.

⁴ *Id.*

⁵ *Id.*

care and overall health care outcomes.⁶ Despite these rankings, which clearly suggest a lack of quality health care in the United States, the figures comparing the amount of money that each of these countries spend on health care are of equal concern.⁷ In 2014, for instance, the United States spent the most money on health care as a percentage of GDP (16.6%) compared to the other ten countries evaluated in The Commonwealth Fund's study, with Switzerland ranked the second highest spender devoting 11.4% of its GDP on health care funding.⁸ Moreover, the United Kingdom, which ranked first in health care system performance, spent only 9.9% of its GDP on health care in 2014.⁹

While these figures speak for themselves, common discourse about health care in the United States has lately focused on several new "buzz words" due to the heated 2020 Democratic Party presidential primaries. In the course of politicians' campaigns for the Democratic presidential nomination, many Americans have heard various proposals to address the nation's health care crisis, which have been glossed in unfamiliar terms such as socialized medicine, "universal health care," "single-payer health plan," and "Medicare For All."¹⁰ On one end of the spectrum, "socialized medicine is, by definition, a health care system in which the government owns and operates health care facilities and employs the health care professionals."¹¹ On the other end, the idea of "Medicare For All" aims to "move the United States in the direction of a single-payer system, where the government steps in (rather than insurance companies) as the intermediary between patients and providers in health-care transactions."¹² Recently, proposals to expand the federal government's role in the provision of

⁶ Eric C. Schneider et al., *Mirror, Mirror 2017: International Comparison Reflects Flaws and Opportunities for Better U.S. Health Care*, THE COMMONWEALTH FUND, July 14, 2017, at 5.

⁷ *Id.* at 4.

⁸ *Id.*

⁹ *Id.* at 4–5.

¹⁰ Joseph Ax, *Where the Top Democratic U.S. Presidential Candidates Stand on 'Medicare for All'*, THOMPSON REUTERS (Sept. 10, 2019), <https://www.reuters.com/article/us-usa-election-healthcare-factbox/where-the-top-democratic-us-presidential-candidates-stand-on-medicare-for-all-idUSKCN1VV13A>.

¹¹ *What is Socialized Medicine?*, HEALTHINSURANCE.ORG, <https://www.healthinsurance.org/glossary/socialized-medicine/> (last visited Sept. 28, 2019, 2:30 PM).

¹² Kevin Uhrmacher et al., *Where 2020 Democrats Stand on Medicare-for-all*, WASH. POST, Sept. 20, 2019, <https://www.washingtonpost.com/graphics/politics/policy-2020/medicare-for-all/>.

health care services have received significant attention in this discussion, with “Medicare For All” dominating the conversation among “[t]he major Democratic presidential contenders.”¹³

I. THESIS

Although many politicians believe that expanding the federal government’s role in the health care industry is the best path for resolving America’s health care crisis, advocates for socialized medicine overlook several drawbacks of federal government intervention and seem to ignore less-extreme alternatives for improving access to health care. This note will evaluate three pathways for increasing access to health care in the United States. In doing so, the legal feasibility and likelihood for success of each pathway will be analyzed in detail. First, the note will discuss the possibility of expanding The Veterans Health Administration model (“the VA Model”). Second, the note will analyze the benefits and disadvantages of the most frequently discussed solution to America’s health care crisis, which is commonly referred to as “Medicare For All.” Last, the note will explain the advantages of expanding the country’s Medicaid program and, in doing so, ultimately argue that this strategy deserves far more attention from the country’s current policymakers and remaining candidates for the United States 2020 presidential election.

II. EXPANDING THE VA MODEL

A. *What is the VA Model?*

The U.S. Department of Veterans Affairs created the Veterans Health Administration to provide free health care services to veterans who served domestically and abroad (“the VA Model”).¹⁴ The VA Model is comprised of “1,255 health care facilities, including 170 medical centers and 1,074 outpatient sites of care of varying complexity” which are located across the United States.¹⁵ Although the VA Model is similar to Medicare and Medicaid in that all three are “publicly funded” programs, most health care services under Medicare and Medicaid are delivered by “private providers in private

¹³ *Id.*

¹⁴ U.S. DEP’T OF VETERANS AFF., *Providing Health Care for Veterans*, VETERANS HEALTH ADMIN. (last updated Oct. 25, 2019), <https://www.va.gov/health/>.

¹⁵ *Id.*

facilities.”¹⁶ The VA Model, by contrast, is essentially “a veteran-specific national health care system” in which “the federal government owns [the health care facilities]” and employs the doctors, nurses and administrative staff who work at these facilities.¹⁷ As the nation’s “largest integrated health care system,” the VA Model provides health care services to roughly nine million veterans annually.¹⁸

Despite the good-hearted intentions of the VA Model to make accessing affordable health care easy for the nation’s former service members, “not all veterans are eligible to receive VA health care services.”¹⁹ To receive treatment at a VA Model facility, a veteran must satisfy the statutory definitions of “veteran” and “active duty” along with showing that he or she “served a minimum period of 24 months of continuous active duty.”²⁰ Assuming a veteran meets these requirements, he or she will be eligible to receive the VA Model’s “standard medical benefits package” which covers treatment under three broad categories of “inpatient care, outpatient care, and prescription drugs.”²¹ Some of the specific services that are provided for under these three categories include surgical care, “mental health care,” “prosthetic devices,” and “orthotic devices.”²² However, there are several major health care services for which veterans, who despite having satisfied the VA Model’s basic eligibility requirements,²³ must also meet additional criteria in order to receive care under the VA Model.²⁴ These include dental care, which is extremely limited under the VA Model,²⁵ and long-term care services such as hospice care,

¹⁶ SIDATH PANANGALA, CONG. RES. SERV., RL 42747, HEALTH CARE FOR VETERANS: ANSWERS TO FREQUENTLY ASKED QUESTIONS 1 (2019).

¹⁷ *Id.*

¹⁸ U.S. DEP’T OF VETERANS AFF., *supra* note 14.

¹⁹ SIDATH PANANGALA, CONG. RES. SERV., RL 42747, HEALTH CARE FOR VETERANS: ANSWERS TO FREQUENTLY ASKED QUESTIONS 2 (2019).

²⁰ *Id.*; see also 38 U.S.C. § 101(2) (2018) (defining “veteran”); 38 U.S.C. § 101(21) (2018) (defining “active duty”); 38 U.S.C. § 5303(a) (2018) (explaining certain bars to receiving Veterans Affairs benefits).

²¹ SIDATH PANANGALA, CONG. RES. SERV., RL 42747, HEALTH CARE FOR VETERANS: ANSWERS TO FREQUENTLY ASKED QUESTIONS 17 (2019); see also 38 C.F.R. § 17.38 (2020).

²² SIDATH PANANGALA, CONG. RES. SERV., RL 42747, HEALTH CARE FOR VETERANS: ANSWERS TO FREQUENTLY ASKED QUESTIONS 18 (2019).

²³ *Id.* at 2; see also 38 U.S.C. § 101(2) (2018) (defining “veteran”); 38 U.S.C. § 101(21) (2018) (defining “active duty”); 38 U.S.C. § 5303(a) (2018) (explaining certain bars to receiving Veterans Affairs benefits).

²⁴ SIDATH PANANGALA, CONG. RES. SERV., RL 42747, HEALTH CARE FOR VETERANS: ANSWERS TO FREQUENTLY ASKED QUESTIONS 12–15 (2019).

²⁵ *Id.* at 20.

which veterans must typically show a need for based on “service-connected” injuries.²⁶

The VA Model also falls short on its intentions to provide health care services that are “free of charge” to eligible veterans.²⁷ Although the VA Model does not require eligible veterans to pay premiums, many veterans still have to pay copayments for health care services they receive through the VA Model that are “related to the treatment of a nonservice-connected condition.”²⁸ For example, eligible veterans who have conditions that are not at least 50% related to injuries suffered from their service have to pay \$15 for “primary care outpatient visits” and \$50 for “specialty care outpatient visits.”²⁹ In regard to receiving medications such as prescription drugs, the majority of eligible veterans can be charged up to \$960 per year.³⁰ Additionally, funding for the VA Model’s health care services does not come cheap to American taxpayers considering that President Trump “is requesting a total of \$220.2 billion in fiscal year 2020 for the U.S. Department of Veterans Affairs.”³¹ Of this \$220.2 billion, the federal government plans to spend \$84.1 billion to provide health care services to an estimated 9.3 million eligible veterans through the VA Model, which is a \$7.3 billion increase from the VA Model’s \$76.8 billion budget for providing health care services in fiscal year 2019.³²

B. Expanding the VA Model is not the best answer for addressing the health care crisis in the United States.

In providing health care services to roughly 9.3 million people,³³ the VA Model is essentially a smaller scale version of what socialized medicine would look like in the United States. Both of these systems require a network of federal government funded health care facilities, but they vary dramatically in scope.³⁴ Simply put, the costs of

²⁶ *Id.* at 23.

²⁷ *Id.* at 31.

²⁸ *Id.*

²⁹ *Id.*

³⁰ *Id.* at 35.

³¹ U.S. DEP’T OF VETERANS AFF., *Annual Budget Submission*, OFF. OF BUDGET (last updated May 3, 2019), <https://www.va.gov/budget/products.asp>.

³² U.S. DEP’T OF VETERANS AFF., *2020 Budget Highlights*, OFF. OF BUDGET (last updated May 3, 2019), <https://www.va.gov/budget/docs/summary/fy2020VAsBudgetFastFacts.pdf>.

³³ *Id.*

³⁴ *What is Socialized Medicine?*, HEALTHINSURANCE.ORG, <https://www.healthinsurance.org/glossary/socialized-medicine/> (last visited Sept.

expanding the VA Model to cover everyone in the United States would be an impractical expenditure of federal taxpayer dollars. Currently, the U.S. Census Bureau estimates that the United States has a population of 329,980,473 people.³⁵ Based on President Trump's plan to spend \$84.1 billion of American taxpayer dollars to provide health care services to 9.3 million eligible veterans through the VA Model in fiscal year 2020,³⁶ it would cost just over \$3 trillion to expand the VA Model to provide health care services to everyone in the United States. Aside from this impractical cost and use of American taxpayer dollars, there are several reasons why expanding the VA Model is not the most effective means for addressing the health care crisis in the United States.

Most notably, the failed attempts to improve the VA Model's efficiency in providing quality health care to patients reveals concerning inadequacies of the VA Model and strongly cautions against expanding the program to cover additional patients.³⁷ According to the U.S. Government Accountability Office ("GAO"), which is responsible for monitoring the spending of federal taxpayer dollars and is often referred to as the Congressional "watchdog agency,"³⁸ the VA Model was formally labeled "as a high-risk area in 2015" based on concerns "regarding [the VA Model's] ability to provide timely access to safe, high-quality health care for veterans."³⁹ Despite being put on notice of its designation "as a high-risk area," GAO found that "little progress had actually been made" to improve the health care facilities associated with the VA Model when GAO reassessed these facilities two years later in 2017.⁴⁰ Specifically, GAO found that VA health care facilities "did not always document or

28, 2019) ("Socialized medicine is, by definition, a health care system in which the government owns and operates health care facilities and employs the health care professionals, thus also paying for health care services.").

³⁵ U.S. CENSUS BUREAU, <https://www.census.gov/popclock/> (last visited Nov. 13, 2019).

³⁶ U.S. DEP'T OF VETERANS AFF., *supra* note 32.

³⁷ U.S. GOV'T ACCOUNTABILITY OFF., MANAGING RISKS AND IMPROVING VA HEALTH CARE, [hereinafter GAO MANAGING RISKS] https://www.gao.gov/keyissues/managingrisksimprovingvahealthcare/issue_summary#t=0 (last visited Nov. 14, 2019).

³⁸ Benjamin Krause, *GAO Report Shows Disqualified Doctors Hired to Treat Veterans*, DISABLEDVETERANS.ORG (Mar. 5, 2019), <https://www.disabledveterans.org/2019/03/05/gao-report-shows-disqualified-va-doctors-hired-to-treat-veterans/>; see also U.S. GOV'T ACCOUNTABILITY OFF., *Overview*, ABOUT GAO, <https://www.gao.gov/about/> (last visited Sept. 29, 2019).

³⁹ GAO MANAGING RISKS, *supra* note 37.

⁴⁰ *Id.*

conduct required reviews of providers” in response to allegations of improper health care services and that, as a result, the leaders of these facilities “lacked the information they needed to ensure that VA providers were competent to provide safe, high-quality health care to veterans.”⁴¹ Additionally, GAO’s 2017 re-assessment of VA Model health care facilities showed that the VA “did not consistently ensure that allegations of misconduct involving senior officials were reviewed . . . or ensure that these officials were held accountable.”⁴²

In light of these documented failures of the VA Model to hold its employees accountable for misconduct,⁴³ the sometimes-questionable standard of care that is offered by unqualified health care practitioners at VA Model facilities further discredits the position of expanding the VA Model.⁴⁴ GAO’s most recent 2019 assessment of VA Model facilities found multiple instances where veterans received medical services from 57 providers who were disqualified from providing care to patients.⁴⁵ Based on USA Today’s study comparing patient reviews between 146 VA Model facilities and private health care facilities,⁴⁶ it is very difficult to doubt the incompetency and underqualified credentials of some of the federal employees who provide health care

⁴¹ *Id.*; see also U.S. GOV’T ACCOUNTABILITY OFF., GAO-18-63, VA HEALTH CARE: IMPROVED POLICIES AND OVERSIGHT NEEDED FOR REVIEWING AND REPORTING PROVIDERS FOR QUALITY AND SAFETY CONCERNS 11 (2017) (“[F]ive selected [VA Model health care facilities] collectively required reviews of 148 providers’ clinical care after concerns were raised from October 2013 through March 2017, but [VA Model health care facilities] officials were unable to provide documentation that almost half of these reviews were conducted.”).

⁴² GAO MANAGING RISKS, *supra* note 37; see also U.S. GOV’T ACCOUNTABILITY OFF., GAO-18-137, DEPARTMENT OF VETERANS AFFAIRS: ACTIONS NEEDED TO ADDRESS EMPLOYEE MISCONDUCT PROCESS AND ENSURE ACCOUNTABILITY 32 (2018) (“[GAO] identified four cases [of alleged misconduct by employees at VA Model health care facilities] that did not contain evidence of an independent review by an official separate from and at a higher pay grade than the accused.”).

⁴³ GAO MANAGING RISKS, *supra* note 37.

⁴⁴ Krause, *supra* note 38; see also U.S. GOV’T ACCOUNTABILITY OFF., GAO-19-6, VETERANS HEALTH ADMINISTRATION: GREATER FOCUS ON CREDENTIALING NEEDED TO PREVENT DISQUALIFIED PROVIDERS FROM DELIVERING PATIENT CARE 20 (2019) (“[P]rovider was hired as a registered nurse by a [VA Model] facility in March 2013 . . . [despite having] surrendered his license in one state in 1998, after the licensing board informed him that it would investigate him due to concerns that the provider ‘may not be safe and competent to practice nursing.’”).

⁴⁵ *Id.*

⁴⁶ Donovan Slack et al., *Death Rates, Bedsores, ER Wait Times: Where Every VA Hospital Lags or Leads Other Medical Care*, USA TODAY (Feb. 7, 2019), <https://www.usatoday.com/in-depth/news/investigations/2019/02/07/where-every-va-hospital-lags-leads-other-care/2511739002/>.

services to veterans at VA Model facilities.⁴⁷ For example, it seems that these federal employees struggle to efficiently operate VA Model facilities considering the study found that 70% of VA Model hospitals had a longer median wait-time between patients' arrivals and admissions than non-VA Model hospitals.⁴⁸ Moreover, the study discovered that sixteen of these VA Model hospitals had median wait-times between patients' arrivals and admissions of 6.5 hours or longer.⁴⁹

In response to these concerns of patient dissatisfaction⁵⁰ and unlicensed physicians treating patients at VA Model facilities,⁵¹ the Veterans' Health Administration ("the VHA") recently announced its new policy of "allowing a broad section of its nine million enrollees to seek medical care outside of traditional [VA] hospitals."⁵² If anything, this announcement is essentially an admission from the VHA that, under its current system, the VHA cannot provide adequate health care services to the roughly nine million eligible veterans who receive treatment at its facilities.⁵³ In coupling this with GAO's consistent scrutiny of VA health care facilities⁵⁴ and documented instances of unlicensed physicians treating patients at these facilities,⁵⁵ the VA Model would surely provide an even worse quality of health care to patients if it were expanded to cover everyone in the United States. Because the VA Model cannot even provide adequate health care services to the estimated nine million veterans it currently attempts to serve,⁵⁶ policymakers should look elsewhere to find an answer for resolving the nation's health care crisis.

⁴⁷ Krause, *supra* note 38; *see also* U.S. GOV'T ACCOUNTABILITY OFF., GAO-19-6, VETERANS HEALTH ADMINISTRATION: GREATER FOCUS ON CREDENTIALING NEEDED TO PREVENT DISQUALIFIED PROVIDERS FROM DELIVERING PATIENT CARE 19-21 (2019).

⁴⁸ Slack et al., *supra* note 46.

⁴⁹ *Id.*

⁵⁰ *Id.*

⁵¹ U.S. GOV'T ACCOUNTABILITY OFF., GAO-19-6, VETERANS HEALTH ADMINISTRATION: GREATER FOCUS ON CREDENTIALING NEEDED TO PREVENT DISQUALIFIED PROVIDERS FROM DELIVERING PATIENT CARE 52 (2019).

⁵² Jennifer Steinhauer, *V.A. Prepares for Major Shift in Veterans' Health Care*, N.Y. TIMES, June 5, 2019, <https://www.nytimes.com/2019/06/05/us/politics/va-health-care-veterans.html>.

⁵³ *Id.*

⁵⁴ GAO MANAGING RISKS, *supra* note 37.

⁵⁵ Krause, *supra* note 38; *see also* U.S. GOV'T ACCOUNTABILITY OFF., GAO-19-6, VETERANS HEALTH ADMINISTRATION: GREATER FOCUS ON CREDENTIALING NEEDED TO PREVENT DISQUALIFIED PROVIDERS FROM DELIVERING PATIENT CARE 19-21 (2019).

⁵⁶ Steinhauer, *supra* note 52.

III. EXPANDING MEDICARE OTHERWISE KNOWN AS “MEDICARE FOR ALL”

A. *What is Medicare?*

Medicare is a federally funded program which is divided into two primary categories, “Part A (Hospital Insurance)” and “Part B (Medical Insurance),” that provides health insurance to three classes of individuals.⁵⁷ These classes of individuals include people who are at least sixty-five years-old, “certain younger people with disabilities” and “people with End-Stage Renal Disease.”⁵⁸ Part A covers services including “inpatient care in a hospital,” “skilled nursing facility care,” “hospice care” and “home health care.”⁵⁹ Part B covers services such as the provision of “durable medical equipment,” “ambulance services,” mental health care and “getting a second opinion before surgery.”⁶⁰ In addition to qualifying as at least one of the three classes of individuals covered by Medicare,⁶¹ individuals must also have a “Medicare health plan” to receive health insurance benefits under the program.⁶² In most instances, Medicare health plans are offered by private companies which have a contract with Medicare to provide Part A and Part B benefits to the individual.⁶³ Unless an individual has one of the more advanced Medicare health plans, Medicare and most Medicare health plans do not cover services such as “long-term care,”

⁵⁷ *What’s Medicare?*, MEDICARE.GOV, <https://www.medicare.gov/what-medicare-covers/your-medicare-coverage-choices/whats-medicare> (last visited Sept. 28, 2019).

⁵⁸ *Id.*

⁵⁹ *What Part A Covers*, MEDICARE.GOV, <https://www.medicare.gov/what-medicare-covers/what-part-a-covers> (last visited Sept. 28, 2019).

⁶⁰ *What Part B Covers*, MEDICARE.GOV, <https://www.medicare.gov/what-medicare-covers/what-part-b-covers> (last visited Sept. 28, 2019); *see also What’s Not Covered by Part A & Part B?*, MEDICARE.GOV, <https://www.medicare.gov/what-medicare-covers/whats-not-covered-by-part-a-part-b> (last visited Sept. 28, 2019) (“Even if Medicare covers a service or item, you generally have to pay your deductible, coinsurance, and copayment.”).

⁶¹ *See What’s Medicare?*, *supra* note 57.

⁶² *What Medicare Health Plans Cover*, MEDICARE.GOV, <https://www.medicare.gov/what-medicare-covers/what-medicare-health-plans-cover> (last visited Sept. 28, 2019).

⁶³ *Id.*; *see also Facts + Statistics: Industry Overview*, INS. INFO. INST., <https://www.iii.org/fact-statistic/facts-statistics-industry-overview> (last visited Sept. 28, 2019) (“Total private health insurance direct written premiums were \$867.5 billion in 2017 . . .”).

“most dental care,” “eye exams related to prescribing glasses” and “hearing aids and exams for fitting them.”⁶⁴

While Medicare has been offered to citizens of the United States for over fifty years,⁶⁵ the program underwent one of its largest expansions on March 23, 2010 when “President Obama signed comprehensive health reform, the Patient Protection and Affordable Care Act [(“the ACA”)], into law.”⁶⁶ For instance, the ACA “[increased the] Medicare Part A (hospital insurance) tax rate on wages by 0.9% (from 1.45% to 2.35%) on earnings over \$200,000 for individual taxpayers and \$250,000 for married couples filing jointly.”⁶⁷ Additionally, the ACA is credited with “encouraging health care providers to emphasize high-value care” and “[strengthen] chronic care management” to Medicare beneficiaries.⁶⁸ In line with the ACA’s expansion efforts, financing Medicare in the United States is incredibly expensive considering that the United States’ government spent \$597 billion on Medicare in 2017 to “[provide] health coverage to around 59 million people.”⁶⁹ Moreover, “[i]n 2018, Medicare benefit payments totaled \$731 billion” which accounted for “15 percent of total federal spending in 2018.”⁷⁰

⁶⁴ *What’s Not Covered by Part A & Part B?*, *supra* note 60.

⁶⁵ *History*, CTR. FOR MEDICARE & MEDICAID SERV. (last updated Jan. 13, 2020, 7:44 PM), <https://www.cms.gov/About-CMS/Agency-information/History/>.

⁶⁶ *Summary of the Affordable Care Act*, THE HENRY J. KAISER FAM. FOUND. (Apr. 25, 2013), <https://www.kff.org/health-reform/fact-sheet/summary-of-the-affordable-care-act/>.

⁶⁷ *Id.*; see also Louise Norris, *Medicare and the Affordable Care Act*, MEDICARERESOURCES.ORG (Apr. 19, 2019), <https://www.medicareresources.org/basic-medicare-information/health-reform-and-medicare/> (discussing how only “the wealthiest fraction of the country” was impacted by the ACA’s increase in federal taxes for Medicare).

⁶⁸ Karen Davis et al., *The Affordable Care Act and Medicare: How the Law is Changing the Program and the Challenges that Remain*, THE COMMONWEALTH FUND, June 9, 2015, at 9-10 (“Since the ACA’s enactment an estimated 37 million Medicare beneficiaries received free preventative services in 2013 [and] 8 million beneficiaries saved over \$11.5 billion in 2010 from discounts.”).

⁶⁹ *Policy Basics: Where Do Our Federal Tax Dollars Go?*, CTR. ON BUDGET AND POL’Y PRIORITIES (Jan. 29, 2019), <https://www.cbpp.org/research/federal-budget/policy-basics-where-do-our-federal-tax-dollars-go>; see also *How is Medicare Funded?*, MEDICARE.GOV, <https://www.medicare.gov/about-us/how-is-medicare-funded> (last visited Sept. 28, 2019) (discussing how “[p]ayroll taxes paid by most employees, employers, and people who are self-employed” comprise the majority of funding for Medicare).

⁷⁰ Juliette Cubanski et al., *The Facts on Medicare Spending and Financing*, THE HENRY J. KAISER FAM. FOUND. (Aug. 20, 2019), <https://www.kff.org/medicare/issue-brief/the-facts-on-medicare-spending-and-financing/>.

Despite these large expenditures of federal tax payer dollars to fund Medicare,⁷¹ many Americans who are covered by Medicare still have to pay out-of-pocket costs to receive health care treatments under the program.⁷² For example, covered individuals who buy Medicare Part A typically “pay up to \$437 each month” unless they “paid Medicare taxes for 30-39 quarters . . . [in which case] the standard Part A premium is \$240” per month.⁷³ Additionally, in order to receive treatment services provided under Medicare Part B, covered individuals must “pay a premium each month” which, for 2019, ranged from \$135.50 to \$460.50 based on the individual’s yearly income in 2017.⁷⁴

B. *‘Medicare For All’ is not a terrible idea but also not the best answer for addressing the health care crisis in the United States.*

Although several politicians have proposed slightly altered variations of what they refer to as their own take on ‘Medicare for All,’⁷⁵ Senator Bernie Sanders’ bill, the “Medicare For All Act of 2019,” has received the most attention from the media and Senator Sanders’ former running mates for the 2020 U.S. presidential election.⁷⁶ Originally introduced in 2017 and reintroduced in 2019, Senator Sanders’ bill is currently sponsored by fourteen other Congress members including one of the former frontrunners for the 2020 U.S. presidential election, Senator Elizabeth Warren.⁷⁷ As the “Medicare For All Act of 2019” provides, its purpose is to clarify, once and for all, that “[e]very individual who is a resident of the United States is entitled to benefits for health care services.”⁷⁸ In order to achieve this purpose, the Act aims to create “[a] single-payer, government-run health care program in which all Americans . . .

⁷¹ See *id.*; *Policy Basics: Where Do Our Federal Tax Dollars Go?*, *supra* note 69.

⁷² See *Part A Costs*, MEDICARE.GOV, <https://www.medicare.gov/your-medicare-costs/part-a-costs> (last visited Sept. 28, 2019); *Part B Costs*, MEDICARE.GOV, <https://www.medicare.gov/your-medicare-costs/part-b-costs> (last visited Sept. 28, 2019).

⁷³ *Part A Costs*, *supra* note 72.

⁷⁴ *Part B Costs*, *supra* note 72.

⁷⁵ Benjy Sarlin & Jeremia Kimelman, *What is ‘Medicare for All’ and How Would It Work?*, NBC NEWS (June 20, 2019), <https://www.nbcnews.com/politics/elections/what-medicare-all-how-would-it-work-n1014256>.

⁷⁶ Sanjay Gupta, *What ‘Medicare for All’ Means Politically and Practically*, CNN (July 2, 2019), <https://www.cnn.com/2019/02/25/health/what-does-medicare-for-all-mean/index.html>.

⁷⁷ *Id.*

⁷⁸ Medicare for All Act of 2019, S.1129, 116th Cong. § 102(a) (2019).

[would be] covered by a more generous version of Medicare.”⁷⁹ Advocates for the “Medicare For All Act of 2019” passionately believe that the Act would provide greatly needed assistance to the many “low-income, and self-employed workers . . . who are among the forty-one million underinsured Americans” living in the country today.⁸⁰ However, there are several reasons why expanding the Medicare program through Senator Sanders’ proposed bill is not the best solution for addressing the health care crisis in the United States.

First and foremost, executing such a drastic expansion of the Medicare program through the “Medicare For All Act of 2019” would eventually “[replace] all private insurance”⁸¹ and eliminate the need for private health insurance companies entirely.⁸² Although the Act provides that it will not become effective until four years have passed from when it is signed into law,⁸³ the Act stipulates that, once this four-year period comes to pass, “it shall be unlawful for . . . a private health insurer to sell health insurance coverage that duplicates the benefits provided under [the] Act.”⁸⁴ This is deeply concerning considering that, in 2017, roughly 156 million people in the United States received their health insurance coverage from their employers,⁸⁵ and the Act would eliminate these “employer-based insurance” programs within four years after its enactment.⁸⁶ Not only would a majority of this group of Americans likely be disappointed in having to switch to and rely on Medicare for their health insurance needs,⁸⁷ but the effect of

⁷⁹ Sarlin & Kimelman, *supra* note 75.

⁸⁰ Teresa Ghilarducci, *What is Medicare For All?*, FORBES (July 16, 2018), <https://www.forbes.com/sites/teresaghilarducci/2018/07/16/what-is-medicare-for-all/#16542145bd0b>.

⁸¹ *Compare Medicare-for-all and Public Plan Proposals*, THE HENRY J. KAISER FAM. FOUND. (May 15, 2019), <https://www.kff.org/interactive/compare-medicare-for-all-public-plan-proposals/>; *see also* Medicare for All Act of 2019, S.1129, 116th Cong. § 107(a) (2019).

⁸² Ghilarducci, *supra* note 80; *see also* Medicare for All Act of 2019, S.1129, 116th Cong. § 107(a) (2019).

⁸³ Medicare for All Act of 2019, S.1129, 116th Cong. § 106(a) (2019).

⁸⁴ *Id.* § 107(a).

⁸⁵ Liz Hamel et al., *Kaiser Family Foundation/LA Times Survey of Adults With Employer-Sponsored Insurance*, THE HENRY J. KAISER FAM. FOUND. (May 2, 2019), <https://www.kff.org/private-insurance/report/kaiser-family-foundation-la-times-survey-of-adults-with-employer-sponsored-insurance/>.

⁸⁶ Haeyoun Park & Margot Sanger-Katz, *How ‘Medicare for All’ Would Affect You*, N.Y. TIMES, Apr. 10, 2019, <https://www.nytimes.com/interactive/2017/09/14/us/impact-of-sanders-medicare-for-all-plan.html>.

⁸⁷ *Winning on Health Care*, THIRD WAY (last updated June 14, 2018), <https://www.thirdway.org/memo/winning-on-health-care> (“Right now, 80% of

eliminating private health insurance would also carry grave consequences for the United States' economy.⁸⁸ Most notably, for example, the estimated 870,600 Americans who work for health insurance companies would likely lose their jobs within four years of the enactment of the "Medicare For All Act of 2019."⁸⁹

Furthermore, the consistent failure of Medicare policymakers to minimize out-of-pocket expenses and additional health care costs for Medicare beneficiaries strongly suggests that the country should proceed with caution in supporting Senator Sanders' efforts to expand the Medicare program.⁹⁰ For instance, even after the Affordable Care Act significantly "[increased the] Medicare Part A (hospital insurance) tax rate" on the country's top earners,⁹¹ in 2016, "[m]ore than one-fourth of all Medicare beneficiaries . . . [still spent] 20 percent or more of their incomes on premiums plus medical care, including cost-sharing and uncovered services."⁹² Additionally, Medicare beneficiaries who are hospitalized for more than 60 days still have to pay "\$335 [in out-of-pocket costs] per day for days 61 through 90 and [then pay] \$670 for up to 60 lifetime reserve days [afterwards]."⁹³

Aside from these issues regarding the destruction of the private health insurance industry, along with the Medicare program's history

[Americans] with employer-sponsored [health care insurance] plans are satisfied with their coverage.").

⁸⁸ *Facts + Statistics: Industry Overview*, *supra* note 63 ("Total private health insurance direct written premiums were \$867.5 billion in 2017 . . .").

⁸⁹ *Id.*

⁹⁰ See Juliette Cubanski et al., *How Much Is Enough? Out-of-Pocket Spending Among Medicare Beneficiaries: A Chartbook*, THE HENRY J. KAISER FAM. FOUND. (July 1, 2014), <https://www.kff.org/medicare/report/how-much-is-enough-out-of-pocket-spending-among-medicare-beneficiaries-a-chartbook/> ("In 2010, Medicare beneficiaries spent \$4,734 out of their own pockets for health care spending, on average, including premiums for Medicare and other types of supplemental insurance and costs incurred for medical and long-term care services."); Claire Noel-Miller, *Medicare Beneficiaries' Out-of-Pocket for Health Care*, AARP PUB. POL'Y INST., Nov. 2017, at 1 ("In 2013, people with traditional Medicare spent an average of \$5,680 on insurance premiums and medical services.").

⁹¹ *Summary of the Affordable Care Act*, *supra* note 66.

⁹² Cathy Schoen et al., *Medicare Beneficiaries' High Out-of-Pocket Costs: Cost Burdens by Income and Health Status*, THE COMMONWEALTH FUND, May 12, 2017, at 2.

⁹³ Emily Brandon, *Medicare Out-of-Pocket Costs You Should Expect to Pay*, U.S. NEWS & WORLD REP. (Mar. 26, 2018, 10:31 AM), <https://money.usnews.com/money/retirement/medicare/articles/2018-03-14/medicare-out-of-pocket-costs-you-should-expect-to-pay>.

of failing to limit its beneficiaries' out-of-pocket expenses,⁹⁴ "the costs [would] be astronomical" to actually fund Senator Sanders' "Medicare For All Act of 2019."⁹⁵ For example, according to the RAND Corporation's latest health care study from 2018, it would cost American tax payers an estimated \$3.89 trillion to provide all of the health care services outlined in Senator Sanders' Act for just one year in the United States.⁹⁶ Not only would taxes for all Americans significantly rise in order to account for this estimated multi-trillion dollar increase in Medicare funding,⁹⁷ but the estimated 156 million people who are insured by their employers and the estimated 21 million "people who buy their own [health] insurance" would be required to pay new taxes for their enrollment into the national Medicare program.⁹⁸

Although Senator Sanders' vision of "guaranteeing health care to all people as a right"⁹⁹ is undoubtedly an admirable cause, his plan for implementing this vision through the enactment of his "Medicare For All Act of 2019" certainly has its fallacies.¹⁰⁰ On its face, Medicare is a broken system which has consistently left millions of American beneficiaries paying out-of-pocket costs in order to receive basic health care services since the program's inception in 1965.¹⁰¹ Not only

⁹⁴ See Ghilarducci, *supra* note 80 (discussing how "[h]ealth insurance companies would mostly be eliminated" if Senator Sanders' "Medicare for All Act of 2019" is enacted into law); Cubanski et al., *supra* note 90; Noel-Miller, *supra* note 90.

⁹⁵ Sarlin & Kimelman, *supra* note 75.

⁹⁶ Jodi Liu & Christine Eibner, *National Health Spending Estimates Under Medicare for All*, RAND CORP. (Mar. 29, 2019), https://www.rand.org/pubs/research_reports/RR3106.html.

⁹⁷ Cubanski et al., *supra* note 70 ("In 2018, Medicare benefit payments totaled \$731 billion, up from \$462 billion in 2008.").

⁹⁸ Park & Sanger-Katz, *supra* note 86.

⁹⁹ HEALTH CARE AS A HUMAN RIGHT – MEDICARE FOR ALL, <https://berniesanders.com/issues/medicare-for-all/> (last visited Oct. 11, 2019).

¹⁰⁰ See Ghilarducci, *supra* note 80 (discussing how "[h]ealth insurance companies would mostly be eliminated" if Senator Sanders' "Medicare for All Act of 2019" is enacted into law); Cubanski et al., *supra* note 90; Noel-Miller, *supra* note 90; Liu & Eibner, *supra* note 96.

¹⁰¹ See Cubanski et al., *supra* note 90 ("In 2010, Medicare beneficiaries spent \$4,734 out of their own pockets for health care spending, on average, including premiums for Medicare and other types of supplemental insurance and costs incurred for medical and long-term care services."); Noel-Miller, *supra* note 90 ("In 2013, people with traditional Medicare spent an average of \$5,680 on insurance premiums and medical services."); Schoen et al., *supra* note 92 ("More than one-fourth of Medicare beneficiaries – 15 million people – spend 20 percent of their incomes on premiums plus medical care, including cost-sharing and uncovered services."); *History*, *supra* note 65 ("On July 30, 1965, President

would Senator Sanders' bill cripple the private health insurance industry while potentially leaving hundreds of thousands of Americans unemployed,¹⁰² but the projected costs that would be shifted to American taxpayers for expanding Medicare under the bill are simply unrealistic.¹⁰³ There is a better solution for addressing the health care crisis facing the United States today.

IV. EXPANDING MEDICAID

A. *What is Medicaid?*

Unlike Medicare, which is entirely controlled and funded by the federal government,¹⁰⁴ "Medicaid is a joint federal and state program . . . which provides health coverage to 72.5 million Americans."¹⁰⁵ Federally mandated groups of Americans that all state-run Medicaid programs must provide benefits to include low income families,¹⁰⁶ pregnant women living in poverty,¹⁰⁷ children who receive adoption or foster care assistance¹⁰⁸ and individuals with certain disabilities.¹⁰⁹ As long as states comply with the federal government's minimum requirements for Medicaid benefits and eligibility, each state is authorized to expand the coverage and eligibility parameters of its Medicaid program at its own discretion.¹¹⁰ For example, some of the major, federally mandated Medicaid benefits that all state Medicaid programs must provide to eligible groups include inpatient hospital services, outpatient hospital services and transportation to medical

Lyndon B. Johnson signed into law the bill that led to the Medicare [program]").

¹⁰² See Ghilarducci, *supra* note 80 (discussing how "[h]ealth insurance companies would mostly be eliminated" if Senator Sanders' "Medicare for All Act of 2019" is enacted into law); *Facts + Statistics: Industry Overview*, *supra* note 63 (reporting that an estimated 870,600 Americans work for health insurance companies).

¹⁰³ See Liu & Eibner, *supra* note 96 ("[T]otal health expenditures under a Medicare for All plan that provides comprehensive coverage and long-term care benefits would be \$3.89 trillion [for a calendar year]").

¹⁰⁴ BARRY R. FURROW ET AL., *HEALTH LAW: CASE, MATERIALS AND PROBLEMS* 826 (7th ed. 2013).

¹⁰⁵ *Eligibility*, MEDICAID.GOV, <https://www.medicaid.gov/medicaid/eligibility/index.html> (last visited Oct. 12, 2019).

¹⁰⁶ See 42 U.S.C. § 1396 (2018).

¹⁰⁷ See 42 C.F.R. § 435.116 (2020).

¹⁰⁸ See *id.* § 435.145.

¹⁰⁹ See 42 U.S.C. § 1383c (2018).

¹¹⁰ FURROW ET AL., *supra* note 104, at 833.

care.¹¹¹ On the other hand, some of the optional Medicaid benefits, which states can decide whether or not to offer in their Medicaid programs, include prescription drugs costs, dental services and hospice care.¹¹² Accordingly, because each state has the freedom to tailor its Medicaid program to meet the unique needs of its constituents, “the benefits provided by Medicaid programs have historically varied significantly from state to state.”¹¹³

Although Medicaid is now well-known as the main “welfare program for the poor,”¹¹⁴ many low-income families and individuals were not eligible to receive coverage under state Medicaid programs until several years after President Obama signed the ACA into law on March 23, 2010.¹¹⁵ For instance, before the ACA was enacted, state Medicaid programs were only federally mandated to cover “certain discrete categories of needy individuals [such as] pregnant women, children, needy families, the blind, the elderly, and the disabled.”¹¹⁶ The ACA, however, drastically changed this standard by stipulating that states would forfeit all of their “existing Medicaid funding” from the federal government unless their state-run Medicaid programs provided coverage to “all individuals under the age of 65 [years-old] with incomes below 133 percent of the federal poverty line” by 2014.¹¹⁷

This new policy initiative of the ACA, however, was never enacted into law because the Supreme Court of the United States held that it was unconstitutional under Congress’ spending powers in *National Federation of Independent Businesses v. Sebelius*.¹¹⁸ The Court largely based its holding on finding that “Medicaid spending [accounted] for over 20 percent of the average state’s total budget, with federal funds covering 50 to 83 percent of those costs.”¹¹⁹ In appreciating the states’ significant reliance on the federal government to fund their Medicaid programs, the Court reasoned that the pressure put on the states by the ACA to either expand their Medicaid coverage or risk losing all federal funding for their Medicaid programs was

¹¹¹ *Mandatory & Optional Medicaid Benefits*, MEDICAID.GOV, <https://www.medicaid.gov/medicaid/benefits/list-of-benefits/index.html> (last visited Oct. 12, 2019).

¹¹² *Id.*

¹¹³ FURROW ET AL., *supra* note 104, at 843.

¹¹⁴ *Id.* at 826.

¹¹⁵ *Id.* at 833; see *Summary of the Affordable Care Act*, *supra* note 66.

¹¹⁶ *Nat’l Fed’n of Indep. Bus. v. Sebelius*, 567 U.S. 519, 575 (2012).

¹¹⁷ *Id.* at 576–81.

¹¹⁸ *Id.* at 584–87.

¹¹⁹ *Id.* at 581.

unconstitutionally coercive as opposed to a permissible, “mild encouragement” from Congress.¹²⁰ Based on this reasoning, the Supreme Court held that the states were free to “voluntarily” follow the ACA’s Medicaid expansion, but the federal government could not cease its Medicaid funding for states that chose not “to accept the terms of the [ACA’s] Medicaid expansion.”¹²¹

Despite having the option to expand Medicaid coverage without risking the forfeiture of federal funding,¹²² the majority of “states have chosen to [follow the ACA’s guidance] and expand coverage to adults” through their state-run Medicaid programs.¹²³ Accordingly, of the roughly 74 million Americans who receive health care services under Medicaid,¹²⁴ 34% are adults between the ages of 19 and 64 years-old, 43% are children aged 18 years-old or younger, 14% are people with disabilities and the remaining 9% are people over the age of 65 years-old.¹²⁵ Moreover, providing this coverage for so many Americans was made possible by the current Medicaid financing system in which the federal government must match the amount of funding that each state puts into its Medicaid program and potentially provide additional federal funding based on “states’ relative per capita income.”¹²⁶ For instance, in 2016, “[t]otal Medicaid spending was \$553 billion” of which 63% was paid by the federal government whereas states covered the remaining 37% to fund their Medicaid programs.¹²⁷

¹²⁰ *Id.*

¹²¹ *Id.* at 587.

¹²² *Id.*

¹²³ *Eligibility, supra* note 105; see also *Status of Medicaid Expansion and Work Requirement Waivers*, THE COMMONWEALTH FUND (last updated Apr. 9, 2020), <https://www.commonwealthfund.org/publications/maps-and-interactives/2019/aug/status-medicaid-expansion-and-work-requirement-waivers> (reporting that “[t]raditionally expanded Medicaid” has been adopted by twenty-eight states along with Washington, D.C.).

¹²⁴ Robin Rudowitz & Allison Valentine, *Medicaid Enrollment & Spending Growth: FY 2017 & 2018*, THE HENRY J. KAISER FAM. FOUND. (Oct. 19, 2017), <http://www.kff.org/medicaid/issue-brief/medicaid-enrollment-spending-growth-fy-2017-2018/>.

¹²⁵ *Medicaid Enrollees by Enrollment Group*, THE HENRY J. KAISER FAM. FOUND. (2014), <https://www.kff.org/medicaid/state-indicator/distribution-of-medicaid-enrollees-by-enrollment-group/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>.

¹²⁶ Robin Rudowitz et al., *Medicaid Financing: The Basics*, THE HENRY J. KAISER FAM. FOUND. (Mar. 21, 2019), <https://www.kff.org/medicaid/issue-brief/medicaid-financing-the-basics/>.

¹²⁷ Rudowitz & Valentine, *supra* note 124.

B. Expanding Medicaid is the best pathway for addressing the health care crisis in the United States.

In comparison to the VA Model and Medicare health care systems, expanding federal funding for Medicaid is the best option for resolving the current health care crisis in the United States. First, Medicaid covers several, essential health care services that are not offered by the VA Model nor Medicare.¹²⁸ For example, while the VA Model provides very limited coverage for childbirth-related expenses¹²⁹ and Medicare provides no coverage to beneficiaries for these expenses,¹³⁰ thirty-three state-run Medicaid programs cover the costs related to the childbirths of eligible beneficiaries.¹³¹ In fact, according to The Henry J. Kaiser Family Foundation's 2018 study, Medicaid pays for "about half of all births" in the United States.¹³² Moreover, unlike Medicare,¹³³ a majority of state-run Medicaid programs cover the

¹²⁸ See *Mandatory & Optional Medicaid Benefits*, *supra* note 111; SIDATH PANANGALA, CONG. RES. SERV., RL 42747, HEALTH CARE FOR VETERANS: ANSWERS TO FREQUENTLY ASKED QUESTIONS 17–30 (2019); *What's Not Covered by Part A & Part B?*, *supra* note 60.

¹²⁹ See SIDATH PANANGALA, CONG. RES. SERV., RL 42747, HEALTH CARE FOR VETERANS: ANSWERS TO FREQUENTLY ASKED QUESTIONS 17–19 (2019); 38 U.S.C. § 1786 (2018).

¹³⁰ See *What's Not Covered by Part A & Part B?*, *supra* note 60.

¹³¹ *Medicaid Benefits: Freestanding Birth Center Services*, THE HENRY J. KAISER FAM. FOUND. (2018), <https://www.kff.org/other/state-indicator/medicaid-benefits-freestanding-birth-center-services/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>.

¹³² Alison Kodjak, *From Birth to Death, Medicaid Affects the Lives of Millions*, NPR (June 27, 2017, 5:01 AM), <https://www.npr.org/sections/health-shots/2017/06/27/534436521/from-birth-to-death-medicare-affects-the-lives-of-millions>; see also *Medicaid Benefits: Freestanding Birth Center Services*, *supra* note 131.

¹³³ See *What's Not Covered by Part A & Part B?*, *supra* note 60.

expenses for other important medical services and devices such as dental care,¹³⁴ eyeglasses¹³⁵ and hearing aids.¹³⁶

Additionally, “transportation to medical care” is one of the most imperative services covered by Medicaid¹³⁷ which beneficiaries of the VA Model and Medicare must either arrange for themselves or pay out-of-pocket to receive.¹³⁸ In covering this service, Medicaid provides payment for the expenses of both emergency medical transportation¹³⁹ and non-emergency medical transportation such as rides to hospitals for doctor’s appointments and check-ups.¹⁴⁰ Not only is providing transportation to medical care facilities an extremely important benefit,¹⁴¹ but it is especially significant given that an

¹³⁴ *Medicaid Benefits: Dental Services*, THE HENRY J. KAISER FAM. FOUND. (2018), <https://www.kff.org/medicaid/state-indicator/dental-services/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D> (reporting that the Medicaid programs of thirty-nine states cover the expenses for dental care to eligible beneficiaries).

¹³⁵ *Medicaid Benefits: Eyeglasses and Other Visual Aids*, THE HENRY J. KAISER FAM. FOUND. (2018), <https://www.kff.org/medicaid/state-indicator/eyeglasses/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D> (reporting that the Medicaid programs of thirty-three states cover the expenses for eyeglasses to eligible beneficiaries).

¹³⁶ *Medicaid Benefits: Hearing Aids and Other Hearing Devices*, THE HENRY J. KAISER FAM. FOUND. (2018), <https://www.kff.org/medicaid/state-indicator/hearing-aids/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D> (reporting that the Medicaid programs of twenty-eight states cover the expenses for hearing aids to eligible beneficiaries).

¹³⁷ *Mandatory & Optional Medicaid Benefits*, *supra* note 111.

¹³⁸ See SIDATH PANANGALA, CONG. RES. SERV., RL 42747, HEALTH CARE FOR VETERANS: ANSWERS TO FREQUENTLY ASKED QUESTIONS 17–30 (2019); *What’s Not Covered by Part A & Part B?*, *supra* note 60.

¹³⁹ *Medicaid Benefits: Ambulance Services*, THE HENRY J. KAISER FAM. FOUND. (2018), <https://www.kff.org/medicaid/state-indicator/ambulance-services/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D> (reporting that the Medicaid programs of forty-six states cover the expenses for ambulance services to eligible beneficiaries).

¹⁴⁰ *Medicaid Benefits: Non-Emergency Medical Transportation Services*, THE HENRY J. KAISER FAM. FOUND. (2018), <https://www.kff.org/medicaid/state-indicator/non-emergency-medical-transportationservices/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D> (reporting that the Medicaid programs of forty-six states cover the expenses for non-emergency medical transportation services to eligible beneficiaries).

¹⁴¹ See Christina DiGangi, *This Man’s 2-mile Ambulance Ride Cost \$2,700. Is that Normal?*, USA TODAY (May 20, 2017, 11:54 AM), <https://www.usatoday.com/story/money/personalfinance/2017/05/20/ambulance-health-care-services-costs/334338001/> (“[T]here are many reasons medical transport services cost hundreds or thousands of dollars.”).

estimated “60 million people . . . [reside] in rural America”¹⁴² and “[n]early a quarter (23%) of Americans in rural areas . . . [complain] that access to good doctors and hospitals is a major problem in their community.”¹⁴³

Furthermore, Medicaid does a far superior job to Medicare in providing services, such as hospice care and nursing care,¹⁴⁴ which Medicare is supposed to provide to eligible beneficiaries.¹⁴⁵ For instance, while beneficiaries may only receive coverage under Medicare for nursing home care “if it’s the only care [they] need,”¹⁴⁶ Medicaid actually pays for the nursing home care of an estimated sixty-two percent of the total residents who receive assistance from “certified nursing [care] facilities” in the United States.¹⁴⁷ This is deeply concerning considering that Medicare is widely known as the

¹⁴² AM. COUNTS STAFF, *One in Five Americans Live in Rural Areas*, U.S. CENSUS BUREAU (Aug. 9, 2017), <https://www.census.gov/library/stories/2017/08/rural-america.html>.

¹⁴³ Onyi Lam et al., *How Far Americans Live from the Closest Hospital Differs by Community Type*, PEW RES. CTR. (Dec. 12, 2018), <https://www.pewresearch.org/fact-tank/2018/12/12/how-far-americans-live-from-the-closest-hospital-differs-by-community-type/>.

¹⁴⁴ See *Medicaid Benefits: Hospice Care*, THE HENRY J. KAISER FAM. FOUND. (2018), <https://www.kff.org/medicaid/state-indicator/hospice-care/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D> (reporting that the Medicaid programs of forty-six states cover the expenses for hospice care); *Medicaid Benefits: Home Health Services – Nursing Services, Home Health Aides, and Medical Supplies/Equipment*, THE HENRY J. KAISER FAM. FOUND. (2018), <https://www.kff.org/medicaid/state-indicator/home-health-services-includes-nursing-services-home-health-aides-and-medical-supplies-equipment/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D> (reporting that the Medicaid programs of forty-six states cover the expenses for nursing services and home health aides).

¹⁴⁵ See *Hospice Care*, MEDICARE.GOV, <https://www.medicare.gov/coverage/hospice-care> (last visited Oct. 13, 2019) (discussing how beneficiaries must have “a life expectancy of 6 months or less” and “sign a statement choosing hospice care instead of other Medicare-covered benefits” in order to be eligible to receive coverage for hospice care under Medicare Part A); *Nursing Home Care*, MEDICARE.GOV, <https://www.medicare.gov/coverage/nursing-home-care> (last visited Oct. 13, 2019) (discussing the limited circumstances in which beneficiaries may be eligible to receive coverage for nursing home care under Medicare Part A).

¹⁴⁶ *Nursing Home Care*, *supra* note 145.

¹⁴⁷ *Distribution of Certified Nursing Facility Residents by Primary Payer Source*, THE HENRY J. KAISER FAM. FOUND. (2017), <https://www.kff.org/other/state-indicator/distribution-of-certified-nursing-facilities-by-primary-payer-source/?currentTimeframe=0&selectedDistributions=medicaid&sort/Model=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>.

primary “health insurance program for the elderly.”¹⁴⁸ Moreover, and in further disagreement with this characterization of Medicare being the presumed major source of health care coverage for seniors,¹⁴⁹ Medicare does not provide its beneficiaries with coverage for “long-term care” services.¹⁵⁰ Medicaid, on the other hand, provides coverage for a broad range of long term-care services¹⁵¹ which is incredibly significant given that “[a]n estimated 12 million Americans [require] long-term care” annually.¹⁵²

Last, Medicaid’s feature of being a “state administered program”¹⁵³ strongly suggests that expanding Medicaid is the best platform for addressing the unique health care needs of Americans living in different states. For instance, under the Medicaid program, states with the highest concentrations of elderly residents like Florida and Maine¹⁵⁴ could proportionally adjust their Medicaid budgets by increasing funding for long-term health care services while, at the same time, states with the highest concentrations of children like Utah and Texas¹⁵⁵ could adjust their Medicaid budgets to increase funding for children’s health care services. The VA Model and Medicare

¹⁴⁸ Sarlin & Kimelman, *supra* note 75; see also Ghilarducci, *supra* note 80 (“Medicare was established . . . [as] universal health care for people over 65 [years-old]”); Gupta, *supra* note 76 (“Medicare . . . is the government-run health insurance program that covers all Americans 65 [years-old] and older”).

¹⁴⁹ Sarlin & Kimelman, *supra* note 75.

¹⁵⁰ *What’s Not Covered by Part A & Part B?*, *supra* note 60; see also Thomas Heath, *It’s a Good Deal for Most Older Americans, but Medicare is Neither Free nor Easy*, WASH. POST, Oct. 11, 2019, https://www.washingtonpost.com/business/economy/its-a-good-deal-for-most-older-americans-but-medicare-is-neither-free-nor-easy/2019/10/11/d52e7d00-eb70-11e9-9306-47cb0324fd44_story.html (“Medicare pays zero towards long-term care.”).

¹⁵¹ See *Mandatory & Optional Medicaid Benefits*, *supra* note 111; see also Maryalene LaPonsie, *Medicare vs. Medicaid*, U.S. NEWS & WORLD REP. (Nov. 21, 2018, 2:20 PM), <https://money.usnews.com/money/personal-finance/family-finance/articles/medicare-vs-medicare> (“Long-term care is also a benefit of Medicaid.”).

¹⁵² *What is Long-Term Care?*, FAM. CAREGIVER ALL. (Jan. 31, 2015), <https://www.caregiver.org/selected-long-term-care-statistics>.

¹⁵³ FURROW ET AL., *supra* note 104, at 833.

¹⁵⁴ *Population Distribution by Age*, THE HENRY J. KAISER FAM. FOUND. (2018), <https://www.kff.org/other/state-indicator/distribution-by-age/?currentTimeframe=0&sortModel=%7B%22collId%22:%22Children%20018%22,%22sort%22:%22desc%22%7D> (reporting that approximately twenty percent of the residents living in Florida and Maine are at least sixty-five years-old).

¹⁵⁵ *Id.* (reporting that 31% of the residents living in Utah and 27% of the residents living in Texas are between the ages of 0 years-old and 18 years-old).

programs, however, are not as well equipped to do the same because they are both uniformly administered throughout the entire country and are exclusively funded and managed by the federal government.¹⁵⁶ Therefore, in a country with a population of approximately 329,980,473 Americans¹⁵⁷ who face varying health care problems, Medicaid is a far superior program for addressing the unique health care needs of citizens from different states as opposed to the uniformly administered VA Model and Medicare programs.¹⁵⁸ Accordingly, increasing the amount of available federal funding for each state's individually administered Medicaid program is the most viable option for addressing the health care crisis in the United States today.

V. ANALYSIS OF EXPANDING THE VA MODEL, MEDICARE AND MEDICAID

A. *Expanding the VA Model is clearly the worst option for addressing the health care crisis in the United States.*

As Section II of this note discussed, the VA Model is plagued by several inherent shortcomings and it would be very unwise to rely on expanding the VA Model to address the nation's health care crisis. For instance, based on the VA Model's projections of spending \$84.1 billion of federal taxpayer dollars to provide health care services to 9.3 million veterans in fiscal year 2020,¹⁵⁹ it would cost approximately \$3 trillion to expand the VA Model to provide health care services to everyone in the United States.¹⁶⁰ Moreover, the VA Model has a documented history of employing underqualified health care practitioners¹⁶¹ and failing to hold its employees accountable for

¹⁵⁶ See SIDATH PANANGALA, CONG. RES. SERV., RL 42747, HEALTH CARE FOR VETERANS: ANSWERS TO FREQUENTLY ASKED QUESTIONS 1 (2019); *What's Medicare?*, *supra* note 57.

¹⁵⁷ U.S. CENSUS BUREAU, *supra* note 35.

¹⁵⁸ See SIDATH PANANGALA, CONG. RES. SERV., RL 42747, HEALTH CARE FOR VETERANS: ANSWERS TO FREQUENTLY ASKED QUESTIONS 1 (2019); *What's Medicare?*, *supra* note 57.

¹⁵⁹ See U.S. DEP'T OF VETERANS AFF., *supra* note 32.

¹⁶⁰ See U.S. CENSUS BUREAU, *supra* note 35 (reporting that the estimated population of the United States is approximately 329,980,473 people).

¹⁶¹ Krause, *supra* note 38; see also U.S. GOV'T ACCOUNTABILITY OFF., GAO-19-6, VETERANS HEALTH ADMINISTRATION: GREATER FOCUS ON CREDENTIALING NEEDED TO PREVENT DISQUALIFIED PROVIDERS FROM DELIVERING PATIENT CARE 20 (2019) ("[P]rovider was hired as a registered nurse by a [VA Model] facility in March 2013 . . . [despite having] surrendered his license in one state in 1998, after

misconduct.¹⁶² Despite these shortcomings, however, advocates of the VA Model may argue that it should be expanded in order to have a health care system that treats all Americans more fairly because such a program would be entirely controlled by the federal government.¹⁶³

Although these advocates correctly maintain that expanding the VA Model would allow the federal government to solely control the provision of health care services in the United States,¹⁶⁴ it is misguided to argue that pursuing this plan would be an effective solution for increasing Americans' access to quality health care services. This is so because, over the past several years, the federal government has noticeably failed to offer high quality health care services to eligible veterans at VA Model facilities.¹⁶⁵ Thus, considering that the federal government cannot competently manage VA Model facilities to provide high quality health care services to the 9.3 million veterans who are eligible to receive treatments at these facilities,¹⁶⁶ it would be extremely ill-advised to expand the VA Model so as to entrust the federal government with the responsibility of providing health care services to the estimated 329,980,473 people who currently live in the United States.¹⁶⁷

the licensing board informed him that it would investigate him due to concerns that the provider 'may not be safe and competent to practice nursing.'").

¹⁶² GAO MANAGING RISKS, *supra* note 37; *see also* U.S. GOV'T ACCOUNTABILITY OFF., GAO-18-137, DEPARTMENT OF VETERANS AFFAIRS: ACTIONS NEEDED TO ADDRESS EMPLOYEE MISCONDUCT PROCESS AND ENSURE ACCOUNTABILITY 32 (2018) ("[GAO] identified four cases [of alleged misconduct by employees at VA Model health care facilities] that did not contain evidence of an independent review by an official separate from and at a higher pay grade than the accused.").

¹⁶³ *See Public Opinion on Single-Payer, National Health Plans, and Expanding Access to Medicare Coverage*, THE HENRY J. KAISER FAM. FOUND. (Jan. 30, 2020), <https://www.kff.org/slideshow/public-opinion-on-single-payer-national-health-plans-and-expanding-access-to-medicare-coverage/> (reporting that seventy-four percent of surveyed Americans "favor the federal government doing more to help provide health insurance for more Americans" as soon as possible).

¹⁶⁴ SIDATH PANANGALA, CONG. RES. SERV., RL 42747, HEALTH CARE FOR VETERANS: ANSWERS TO FREQUENTLY ASKED QUESTIONS 1 (2019) (discussing how the VA Model is "a veteran-specific national health care system" in which "the federal government owns [the health care facilities]" and employs the doctors, nurses and administrative staff who work at these facilities).

¹⁶⁵ *See* GAO MANAGING RISKS, *supra* note 37 ("GAO designated VA [Model] health care as a high-risk area in 2015 . . . regarding [the VA Model's] ability to provide timely access to safe, high-quality health care for veterans . . . In 2017, GAO reported that while [Veterans Affairs] had taken some actions to address these issues, little progress had actually been made.").

¹⁶⁶ *See* U.S. DEP'T OF VETERANS AFF., *supra* note 32.

¹⁶⁷ U.S. CENSUS BUREAU, *supra* note 35.

Additionally, if an attempt were made to expand the VA Model to provide health care services to everyone in the United States, it is quite difficult to imagine a reality in which the federal government would take ownership of and operate the country's 6,146 hospitals.¹⁶⁸ Although it could be constitutionally permissible for the federal government to do so under the Takings Clause of the Fifth Amendment,¹⁶⁹ it is very doubtful that the federal government would have the resources to effectively manage the estimated seven million employees,¹⁷⁰ including approximately 950,000 licensed physicians,¹⁷¹ who work at these facilities. Therefore, coupling these concerns about the feasibility of implementing an expanded VA Model with GAO's recent scrutiny of the quality of the health care services that veterans have received at VA Model facilities,¹⁷² American politicians must concentrate their efforts on exploring other solutions for combatting the nation's health care crisis.

B. Laypersons and politicians should shift the conversation from "Medicare For All" to "Medicaid for All" when discussing the health care crisis in the United States.

As discussed in Sections III and IV of this note, Americans must be wary of joining the increasingly popular movement for expanding the nation's Medicare program through the adoption of a "Medicare For All" health care plan.¹⁷³ Although Senator Sanders' mission to "[guarantee] health care to all people as a right" by enacting his

¹⁶⁸ See *Fast Facts on U.S. Hospitals, 2020*, AM. HOSP. ASS'N, <https://www.aha.org/statistics/fast-facts-us-hospitals> (last visited Oct. 14, 2019).

¹⁶⁹ U.S. CONST. amend. V; see also *Youngstown Sheet & Tube Co. v. Sawyer*, 343 U.S. 579, 588 (1952) (discussing Congress' power to "authorize the taking of private property for public use" so long as the government provides just compensation).

¹⁷⁰ *U.S. Hospitals – Statistics & Facts*, STATISTA (Nov. 29, 2019), <https://www.statista.com/topics/1074/hospitals/>.

¹⁷¹ See Aaron Young et al., *A Census of Actively Licensed Physicians in the United States*, 103 J. MED. REG. 7, 7 (discussing that in 2016 there were "a total of 953,695 actively licensed allopathic and osteopathic physicians" in the United States).

¹⁷² See GAO MANAGING RISKS, *supra* note 37 ("GAO designated VA [Model] health care as a high-risk area in 2015 . . . regarding [the VA Model's] ability to provide timely access to safe, high-quality health care for veterans . . . In 2017, GAO reported that while [Veterans Affairs] had taken some actions to address these issues, little progress had actually been made.").

¹⁷³ Gupta, *supra* note 76 ("Medicare is quite popular as it stands now."); see also Uhrmacher et al., *supra* note 12.

“Medicare For All Act of 2019” is certainly an admirable cause,¹⁷⁴ the economic consequences of implementing such ambitious legislation significantly outweigh the benefits of doing so. For instance, such a drastic expansion of the country’s Medicare program would “[replace] all private insurance”¹⁷⁵ and eliminate the need for private health insurance companies within four years of enacting Senator Sanders’ bill.¹⁷⁶ Moreover, if the “Medicare For All Act of 2019” is ratified, the estimated 870,600 Americans who work for health insurance companies would lose their jobs¹⁷⁷ and roughly 177 million Americans would be required to pay new taxes for their enrollment into the national Medicare program.¹⁷⁸

Despite these pressing drawbacks along with concerns that taxes for many Americans would substantially rise in order to account for the \$3.89 trillion necessary for providing all of the health care services promised in Senator Sanders’ bill,¹⁷⁹ many Americans favor the adoption of a “Medicare For All” health care plan.¹⁸⁰ In fact, according to The Henry J. Kaiser Family Foundation’s 2019 study, seventy-one percent of surveyed Americans stated that they would support “a national Medicare-for-all plan” which “[guarantees] health insurance as a right for all Americans.”¹⁸¹ Considering that there are approximately 1,000 health insurance companies in the United States which offer various health care plans that provide coverage for

¹⁷⁴ HEALTH CARE AS A HUMAN RIGHT – MEDICARE FOR ALL, <https://berniesanders.com/issues/medicare-for-all/> (last visited Oct. 11, 2019).

¹⁷⁵ *Compare Medicare-for-all and Public Plan Proposals*, THE HENRY J. KAISER FAM. FOUND. (last updated May 15, 2019),

<https://www.kff.org/interactive/compare-medicare-for-all-public-plan-proposals/>; see also Medicare for All Act of 2019, S.1129, 116th Cong. § 107(a) (2019),

¹⁷⁶ Ghilarducci, *supra* note 80; see also Medicare for All Act of 2019, S.1129, 116th Cong. § 106(a)–107(a) (2019).

¹⁷⁷ *Facts + Statistics: Industry Overview*, *supra* note 63.

¹⁷⁸ Park & Sanger-Katz, *supra* note 86 (discussing that, if Senator Sanders’ bill is enacted, 156 million Americans who are insured by their employers and roughly twenty-one million Americans “who buy their own [health] insurance” would be required to pay new taxes for their enrollment into the national Medicare program).

¹⁷⁹ See Cubanski et al., *supra* note 70; Liu & Eibner, *supra* note 96 (“[T]otal health expenditures under a Medicare for All plan that provides comprehensive coverage and long-term care benefits would be \$3.89 trillion [for a calendar year] . . .”).

¹⁸⁰ *Public Opinion on Single-Payer, National Health Plans, and Expanding Access to Medicare Coverage*, THE HENRY J. KAISER FAM. FOUND. (Jan. 30, 2020), <https://www.kff.org/slideshow/public-opinion-on-single-payer-national-health-plans-and-expanding-access-to-medicare-coverage/>.

¹⁸¹ *Id.*

different treatments,¹⁸² it is likely that many of these Americans favor the adoption of a “Medicare For All” plan because they believe that the health care industry would operate more efficiently under such a plan. In other words, many proponents of “Medicare For All” believe that implementing a “Medicare For All” health care system would greatly simplify the process of accessing health care in the United States because health care services would be uniformly administered through a “single-payer system” in which the federal government, “rather than insurance companies,” would serve “as the intermediary between patients and providers in health-care transactions.”¹⁸³

Although advocates of “Medicare For All” might be correct in arguing that adopting such a plan would conveniently streamline the process of accessing health care services in the United States, there are still several problems associated with adopting a “Medicare For All” health care system. Aside from the impractical costs that American taxpayers would have to bear if the “Medicare For All Act of 2019” were enacted,¹⁸⁴ critics can persuasively argue that Senator Sanders’ bill could be struck down as an unconstitutional exercise of Congress’ taxing power based on the Fifth Circuit’s recent holding in *Texas v. United States*.¹⁸⁵ In *Texas*, the Fifth Circuit refused to follow the Supreme Court of the United States’ decision in *National Federation of Independent Businesses v. Sebelius* by contrarily holding that the ACA’s individual mandate was no longer a permissible exercise of Congress’ taxing power.¹⁸⁶

The original form of the ACA’s individual mandate, when *Sebelius* was decided in 2012, “require[d] most Americans to maintain ‘minimum essential’ health insurance coverage” or to otherwise “make a ‘[s]hared responsibility payment’ to the Federal Government.”¹⁸⁷ In announcing that this “requirement that certain individuals pay a financial penalty for not obtaining health insurance may reasonably be characterized as a tax,” the *Sebelius* Court held that the ACA’s

¹⁸² NAT’L ASS’N OF INS. COMMISSIONERS, U.S. HEALTH INSURANCE INDUSTRY | 2018 ANNUAL RESULTS 1 (2019).

¹⁸³ Uhrmacher et al., *supra* note 12.

¹⁸⁴ See Cubanski et al., *supra* note 70; Liu & Eibner, *supra* note 96 (“[T]otal health expenditures under a Medicare for All plan that provides comprehensive coverage and long-term care benefits would be \$3.89 trillion [for a calendar year] . . .”).

¹⁸⁵ See U.S. CONST. art. I, § 8, cl. 1; *Texas v. United States*, 945 F.3d 355 (2019).

¹⁸⁶ *Texas*, 945 F.3d at 393; see also Nat’l Fed’n of Indep. Bus. v. *Sebelius*, 567 U.S. 519, 574 (2012) (“[The ACA’s] requirement that certain individuals pay a financial penalty for not obtaining health insurance may reasonably be characterized as a tax.”).

¹⁸⁷ *Sebelius*, 567 U.S. at 519; see also 26 U.S.C. § 5000A(a)–(b)(1) (2012).

individual mandate was a constitutional exercise of Congress' taxing power.¹⁸⁸ However, because The Tax Cuts and Jobs Act of 2017 amended the ACA's individual mandate and set the shared responsibility payment amount to zero,¹⁸⁹ the *Texas* court found that the newly amended shared responsibility payment of the ACA's individual mandate no longer "produced revenue" for the federal government.¹⁹⁰ As a result of this finding, the *Texas* court reasoned that the newly amended individual mandate of the ACA could no longer be interpreted as constitutional exercise of Congress' taxing power and accordingly held that it was an unconstitutional, "command to purchase insurance" that the plaintiffs did not want to purchase.¹⁹¹

In light of this recent decision from the Fifth Circuit, critics of Senator Sanders' bill can argue that the "Medicare For All Act of 2019" is strikingly similar to the newly amended individual mandate of the ACA in that it is essentially a "command to purchase insurance"¹⁹² because it forces all Americans to pay for their enrollment into the bill's national Medicare program.¹⁹³ Although many Americans would be buying into this national Medicare program by paying new and higher taxes,¹⁹⁴ the Supreme Court of the United States could be persuaded to interpret this provision of Senator Sanders' bill as an unconstitutional abuse of Congress' taxing power because, for many Americans,¹⁹⁵ the bill would principally function as a "command to purchase insurance" that they do not want to purchase.¹⁹⁶ Moreover, if the Supreme Court affirms *Texas* and adopts

¹⁸⁸ *Sebelius*, 567 U.S. at 574.

¹⁸⁹ *Texas*, 945 F.3d at 390; *see also* 26 U.S.C. § 5000A(c)(2)(B)(iii) (2018).

¹⁹⁰ *Texas*, 945 F.3d at 393.

¹⁹¹ *Id.* at 390–93.

¹⁹² *Id.* at 390.

¹⁹³ Park & Sanger-Katz, *supra* note 86 (discussing that, if Senator Sanders' bill is enacted into law, an estimated 156 million people who are insured by their employers along with the estimated twenty-one million people "who buy their own [health] insurance" would be required to pay new taxes for their enrollment into the national Medicare program).

¹⁹⁴ *Id.*

¹⁹⁵ Megan McArdle, *Sorry, Bernie, but Most Americans Like Their Health Insurance the Way It Is*, WASH. POST, May 3, 2019, <https://www.washingtonpost.com/opinions/2019/05/03/sorry-bernie-most-americans-like-their-health-insurance-way-it-is/> ("[R]oughly 7 out of every 10 Americans report that they're fairly satisfied with the quality of their personal [health care] coverage."); *see also* Justin McCarthy, *Most Americans Still Rate Their Healthcare Quite Positively*, GALLUP (Dec. 7, 2018), <https://news.gallup.com/poll/245195/americans-rate-healthcare-quite-positively.aspx>.

¹⁹⁶ *Texas*, 945 F.3d at 390.

the Fifth Circuit's hesitance for accepting legislation that pressures the public to buy into health care insurance plans,¹⁹⁷ critics of Senator Sander's bill could make an even stronger argument that the "Medicare For All Act of 2019" is an unconstitutional exercise of Congress' taxing power. Therefore, under these circumstances, critics of the "Medicare For All Act of 2019" could offer a very convincing argument that Senator Sanders' bill should be struck down like the newly amended individual mandate of the ACA.

Furthermore, given the inherent issues with expanding the Medicare program,¹⁹⁸ the United States would be much better equipped to address its health care crisis if laypersons and politicians shifted the national conversation about adopting a "Medicare For All" plan to focus on implementing a "*Medicaid* For All" solution. For instance, the majority of state-run Medicaid programs offer coverage for several essential health care services¹⁹⁹ that are currently not provided to eligible beneficiaries of Medicare.²⁰⁰ Additionally, Medicaid has historically been more effective in providing certain health care services, such as hospice care and nursing care,²⁰¹ which the country's Medicare program promised to offer coverage for but has only provided to Medicare beneficiaries who meet restrictive eligibility requirements.²⁰²

¹⁹⁷ *Id.*

¹⁹⁸ See Liu & Eibner, *supra* note 96 ("[T]otal health expenditures under a Medicare for All plan that provides comprehensive coverage and long-term care benefits would be \$3.89 trillion [for a calendar year] . . ."); *Compare Medicare-for-all and Public Plan Proposals*, *supra* note 175 (discussing how "all private insurance" would be replaced if Senator Sanders' "Medicare For All Act of 2019" is enacted into law).

¹⁹⁹ See *Medicaid Benefits: Freestanding Birth Center Services*, *supra* note 131 (reporting that thirty-three state-run Medicaid programs cover the costs related to childbirths of eligible beneficiaries); *Mandatory & Optional Medicaid Benefits*, *supra* note 111 (discussing that "[t]ransportation to medical care" is a mandatory benefit that state-run Medicaid programs are required to provide).

²⁰⁰ See *What's Not Covered by Part A & Part B?*, *supra* note 60.

²⁰¹ See *Medicaid Benefits: Hospice Care*, *supra* note 144 (reporting that the Medicaid programs of forty-six states cover the expenses for hospice care); *Medicaid Benefits: Home Health Services – Nursing Services, Home Health Aides, and Medical Supplies/Equipment*, *supra* note 144 (reporting that the Medicaid programs of forty-six states cover the expenses for nursing services and home health aides).

²⁰² See *Hospice Care*, *supra* note 145 (discussing how beneficiaries must have "a life expectancy of 6 months or less" and "sign a statement choosing hospice care instead of other Medicare-covered benefits" in order to be eligible to receive coverage for hospice care under Medicare Part A); *Nursing Home Care*, *supra* note 145 (discussing the limited circumstances in which beneficiaries may be eligible to receive coverage for nursing home care under Medicare Part A).

Despite these comparisons, there are still several critics of Medicaid who believe that the program should not be expanded.²⁰³ For example, many critics of Medicaid base their disapproval for expanding the program on the fact that, because “Medicaid is a joint federal and state program”²⁰⁴ which authorizes each state to select the health care services its program will offer to its citizens, “the benefits provided by Medicaid programs have historically varied significantly from state to state.”²⁰⁵ Therefore, because Americans who live in different states may not receive coverage for the same health care services,²⁰⁶ these critics argue that Medicaid is an inherently unfair health care system and thus it should not be expanded.

Although this critique of Medicaid expansion properly draws attention to the concern that citizens living in different states may not receive coverage for the exact same health care services under their states’ respective Medicaid programs, expanding Medicaid is still the best means for improving access to quality health care in the United States. In comparison to Medicare which is uniformly administered throughout the country by the federal government,²⁰⁷ Medicaid’s feature of being a “state administered program”²⁰⁸ makes it the most appropriate framework for providing high quality health care services to American constituents living under a federalist system of government.²⁰⁹ As a result, and unlike a uniformly administered “Medicare For All Plan,”²¹⁰ expanding Medicaid would dramatically increase the capability of each state government to individually tailor its Medicaid program so as to devote more funding to the specific health care services that the majority of its citizens require. Thus, while citizens from different states may not have coverage for the exact same health care services under an expanded Medicaid program,

²⁰³ See Merrill Matthews, *Seven Reasons States Should Just Say No To Medicaid Expansion*, FORBES (Dec. 7, 2012), <https://www.forbes.com/sites/merrillmatthews/2012/12/07/seven-reasons-state-should-just-say-no-to-medicaid-expansion/#8ee9da6103ed>; Deane Waldman & Dayal Rajagopalan, *Medicaid Expansion Was – And Is – A Bad Mistake*, INV. BUS. DAILY (Aug. 8, 2017), <https://www.investors.com/politics/commentary/medicaid-expansion-was-and-is-a-bad-mistake/>.

²⁰⁴ *Eligibility*, *supra* note 105.

²⁰⁵ FURROW ET AL., *supra* note 104, at 843.

²⁰⁶ *Id.*

²⁰⁷ See *What’s Medicare?*, *supra* note 57.

²⁰⁸ FURROW ET AL., *supra* note 104, at 833.

²⁰⁹ See *Federalism*, USHISTORY.ORG, <https://www.ushistory.org/gov/3.asp> (last visited Jan. 17, 2020) (“In a federal system, power is shared by the national and state governments.”).

²¹⁰ See *What’s Medicare?*, *supra* note 57.

citizens of each state would receive a higher quality of care for the treatments and procedures that the majority of citizens living in their state most desperately need.

Furthermore, in comparison to dealing with the consequences of eliminating the private health insurance industry if Senator Sanders' "Medicare For All Act of 2019" were enacted into law,²¹¹ expanding the United States' Medicaid program would be fairly simple. For instance, under the current Medicaid financing system, the federal government is required to at least match the amount of funding that state governments devote to their respective Medicaid programs.²¹² Thus, it would be relatively easy to expand the country's Medicaid program by requiring the federal government to provide more federal tax dollars rather than simply matching the amount of funding that each state puts into its own Medicaid program. For example, legislators could pass a law to oblige the federal government to provide one and one half or double the amount of funding that each state spends on its Medicaid program annually. Therefore, by passing such legislation, the United States' Medicaid program would be substantially expanded because each state would have more total funding to apportion among the various health care services it decides to provide coverage for based on the health care needs of its constituents.

Accordingly, expanding the nation's Medicaid program by passing such legislation is an attractive solution for addressing the nation's health care crisis because there are no foreseeable constitutional barriers to adopting such an expansion plan.²¹³ In *Sebelius*, the Supreme Court of the United States held that pressuring the states to expand their Medicaid programs to cover "all individuals under the age of 65 [years-old] with incomes below 133 percent of the federal poverty line" was unconstitutional because doing so was more than a mere, "mild encouragement" from Congress.²¹⁴ Here, under *Sebelius*,²¹⁵ no constitutional issues would be raised if Congress passed legislation to simply provide states with more federal funding to

²¹¹ See Ghilarducci, *supra* note 80; Medicare for All Act of 2019, S.1129, 116th Cong. § 106(a)–107(a) (2019); see also *Facts + Statistics: Industry Overview*, *supra* note 63 (reporting that an estimated 870,600 Americans work for health insurance companies).

²¹² Robin Rudowitz et al., *Medicaid Financing: The Basics*, THE HENRY J. KAISER FAM. FOUND. (Mar. 21, 2019), <https://www.kff.org/report-section/medicaid-financing-the-basics-issue-brief/>.

²¹³ See *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 567 U.S. 519, 581 (2012).

²¹⁴ *Id.* at 576–81.

²¹⁵ *Id.*

expand their Medicaid programs because each state could decide how to utilize the increased funding based on the unique health care needs of its constituents. Moreover, while federal taxes would naturally rise in order to support this additional funding for state-run Medicaid programs, Congress could set the increase in federal taxes at a much more reasonable limit than the excessive amount that Americans would have to pay under the “Medicare For All Act of 2019.”²¹⁶ Therefore, laypersons and politicians must focus the national conversation about health care on adopting a “*Medicaid For All*” strategy as opposed to only discussing “Medicare For All” solutions.

VI. CONCLUSION

Today, there are approximately “18.2 million fewer” Americans who have health insurance than there were in 2010.²¹⁷ Among eleven of the world’s most developed countries, “[t]he United States ranks last in health care system performance.”²¹⁸ This note explored three possible solutions for addressing the health care crisis in the United States. First, the note discussed that expanding the VA Model is the worst option for increasing access to health care because this health care system has a long history of employing underqualified practitioners²¹⁹ and failing to hold these employees accountable for their misconduct.²²⁰ Second, the note claimed that the country should abandon the most popular proposal, Senator Sanders’ “Medicare For All Act of 2019,”²²¹ because enacting this legislation would inevitably eliminate the private health insurance industry²²² and require \$3.89

²¹⁶ See Liu & Eibner, *supra* note 96 (“[T]otal health expenditures under a Medicare for All plan that provides comprehensive coverage and long-term care benefits would be \$3.89 trillion [for a calendar year] . . .”).

²¹⁷ Cohen et al., *supra* note 3.

²¹⁸ Schneider et al., *supra* note 6.

²¹⁹ See Krause, *supra* note 38; U.S. GOV’T ACCOUNTABILITY OFF., GAO-19-6, VETERANS HEALTH ADMINISTRATION: GREATER FOCUS ON CREDENTIALING NEEDED TO PREVENT DISQUALIFIED PROVIDERS FROM DELIVERING PATIENT CARE 20 (2019).

²²⁰ GAO MANAGING RISKS, *supra* note 37; U.S. GOV’T ACCOUNTABILITY OFF., GAO-18-137, DEPARTMENT OF VETERANS AFFAIRS: ACTIONS NEEDED TO ADDRESS EMPLOYEE MISCONDUCT PROCESS AND ENSURE ACCOUNTABILITY 32 (2018).

²²¹ See Gupta, *supra* note 76.

²²² See Ghilarducci, *supra* note 80; see also Medicare for All Act of 2019, S.1129, 116th Cong. § 106(a)–107(a) (2019).

trillion of federal taxpayer dollars in order to provide health care services to Americans for just one year.²²³

Last, the note argued that expanding the country's Medicaid program is the best means for increasing access to higher quality health care in the United States. As a "state administered program,"²²⁴ expanding Medicaid would provide states with more available funding to offer higher quality health care services and allow these local governments to more effectively tailor their Medicaid programs to meet the unique health care needs of their constituents. Because "Medicare For All" continues to dominate the conversation among politicians for resolving the United States' health care crisis,²²⁵ Americans must encourage these policymakers to consider alternative solutions. Passing legislation to expand Medicaid is the nation's best hope for taking care of its citizens who desperately need access to higher quality health care services.

²²³ See Liu & Eibner, *supra* note 96.

²²⁴ FURROW ET AL., *supra* note 104, at 833.

²²⁵ See Uhrmacher et al., *supra* note 12.